

LIMITATIONS:

17. Nurse-Midwife Services

Nurse-midwife services are provided as specified in the Policies and Procedures Manual for Nurse-Midwife Services.

The scope of service is the management and care of pregnant women and newborns throughout the maternity cycle to include uncomplicated pregnancy, labor, birth, and the sixty day postpartum period as well as services that midwives are authorized to perform under State Law that are outside the maternity cycle.

Providers must be currently licensed as registered professional nurses and be currently certified as nurse-midwives by the American College of Nurse-Midwives.

Non-covered services include:

Any procedure outside the legal scope of nurse-midwife services.

Obstetrical care rendered to recipients who arbitrarily travel to other states to bear children for non-medical reasons.

Assisting physicians during delivery.

Services identified as rural health clinic services are subject to policies and procedures governing the Rural Health Clinic Program.

18. Hospice Care

Hospice care services are furnished by Medicare certified hospices enrolled in the Medicaid program. Services are available to eligible individuals who are certified as being terminally ill and having a medical prognosis that his or her life expectancy is six months or less.

An eligible individual must voluntarily elect this service and file an election statement with a Medicaid participating hospice provider.

Hospice coverage is available for an unspecified number of days, subdivided into four election periods as follows: Two periods of 90 days each, a subsequent period of 30 days, and a subsequent extension period of an unspecified number of days.

A recipient may revoke the election of hospice care at any time during the election period. Medicaid coverage of benefits waived during the election period is resumed.

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AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services and Tuberculosis related services

- a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A, (in accordance with Section 1905(a)(19) or Section 1915(g) of the Act).

X Provided: X With limitations*

 Not provided.

- b. Special tuberculosis (TB) related services under Section 1902(z)(2) of the Act.

 Provided: With limitations*

X Not provided.

20. Extended services for pregnant women.

- a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and for any remaining days in the month in which the 60th day falls.

X Additional coverage++

- b. Services for any other medical conditions that may complicate pregnancy.

 Additional coverage++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

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ATTACHMENT 3.1-A
Page 8a
OMB No.: 0938-

State/Territory: GEORGIA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by ~~an eligible~~ ^{eligible} provider (in accordance with section 1920 of the Act).

☐ Provided: ☐ No limitations ☐ With limitations*

☒ Not provided.

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

☐ Provided: ☐ No limitations ☐ With limitations*

☒ Not provided.

CERTIFIED

23. ^APediatric or family nurse practitioners' services.

Provided: ☐ No limitations ☒ With limitations*

*Description provided on attachment.

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NOT IN USE

19. CASE MANAGEMENT SERVICES

Limitations

Case management providers must meet the conditions established by the Department of Human Resources (DHR) and contained in the DHR Grants-to-Counties Manual and the Division of Mental Health, Mental Retardation and Substance Abuse (MH/MR/SA) Policy Memorandum 40-01 and Standards Manual. Services are provided to eligible recipients who are emotionally or mentally disturbed, drug or alcohol abusers, and mentally retarded or developmentally disabled. Available service:

Demonstrated medically necessary case management services which are an integral part of aiding the eligible recipients to overcome their health related disabilities and to attain their highest level of independence or self-care.

Medically necessary is a term used to describe a service which is reasonably calculated to prevent the worsening of conditions that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the recipient receiving the service.

The following criteria must be met prior to admission to service:

1. Physician order as evidenced in the Individualized Service Plan, and,
2. The client meets the Division of Mental Health, Mental Retardation and Substance Abuse criteria for Most-In-Need status, and,
3. One or more of the following:
 - a. the client has been discharged from "inpatient" service two or more times in the previous 12 months, or
 - b. the client is currently residing in a living arrangement financially supported by the Department of Human Resources, or
 - c. the client has a history of severe and disabling mental illness or substance abuse and is "homeless." Homeless is defined as: determination by area mental health, mental retardation and substance abuse service programs, by whatever means, that an individual is undomiciled,

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- i.e., one who lives with neither family nor in a board and care home, a single room occupancy hotel, a nursing home or in his/her home or apartment; has a history of persistent, continuous or intermittent use of shelter services; and is unable to secure permanent or stable housing, or
- d. the client is on an outpatient court ordered commitment status, or
 - e. the client would be eligible for services under the provisions of Title XIX (Medicaid) 2176 Waivers, or
 - f. the client is receiving Clozaril as a part of a treatment plan formulated by the Area Mental Health, Mental Retardation and Substance Abuse Program, and,
4. The client exhibits one or more of the following:
- a. Repeated, long term use of restrictive intensive care settings.
 - b. Noncompliance with treatment or failure to access needed services.
 - c. Frequent crisis episodes.
 - d. Multiple programs (dual diagnoses, medical fragility).
 - e. Need for multiple services and their coordination.
 - f. Lack or inadequacy of natural supports.

Prior Approval for case management service will be given by the Department of Human Resources to any enrolled provider on Form DMA-80, Prior Authorization Request.

Case Management Services Include:

- 1. Assessment of prescribed recommended services in the physician plan of care and identification of those services which have not been adequately assessed over time, resulting in client deterioration and the use of unexplained intensive care services such as emergency crisis intervention or hospitalization.
- 2. Development of specific 24 hour service plan for each client to assure adequate medical, pharmacy and other needed services.
- 3. Establishment of relationships between patient and medically necessary services.
- 4. Assisting the patient in attaining or retaining capability for independence or self care. Assistance will be limited

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to management and/or coordination efforts and will not include the direct provision of services by the case manager.

5. Monitoring service delivery to continually evaluate patient status and quality of services provided.
6. Discharge planning coordination to hospital inpatients.
This is the only service provided hospital inpatients.

Non-Covered Services

No services provided in nursing homes or prisons will be covered.

No counseling services will be provided by case managers.

No services to enrolled clients in an Institution for Mental Diseases (IMD) Units will be covered, however, clients may remain enrolled in the case management program and services resumed upon discharge from an IMD Unit.

Medicaid will not pay for Case Management services that duplicate case management services provided to eligible recipients through the Early Intervention Case Management Program.

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20. Extended Services to Pregnant Women

POSTPARTUM SERVICES

- a.+1 Pregnancy-related and postpartum services are provided through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends.

Definition of Service:

Postpartum visits consist of a maximum of two visits to be provided within 28 days following the mother's discharge from the hospital or birthing center. Components of these visits may include but are not limited to:

1. review of the history of the pregnancy and the delivery.
2. medical assessment of the woman's postpartum recovery.
3. evaluation of the infant's status to assess medical problems which may have occurred during or after delivery, feeding habits and general health problems.
4. evaluation of the social and environmental conditions of the home.
5. drawing blood from the infant for a metabolic screen, if needed.
6. health education on infant care, postpartum recovery and family planning.
7. Providers must make referrals for the provisions of EPSDT, WIC, family planning and prenatal and postpartum services, as may be indicated.

Limitations:

Providers of this service are limited to qualified medical professionals; physicians, nurse midwives, physician's assistants, nurse practitioners and registered nurses. Reimbursement is limited to two (2) postpartum home visits per recipient every 280 calendar days.

Provider Qualifications:

Enrollment is open to all providers who can meet the following requirements:

1. Staff performing the service must be physicians, nurse midwives, physician's assistants, nurse practitioners or registered nurses experienced in the provision of maternal and child health care and be fully licensed by the State of Georgia.
2. Staff must possess the clinical skills to complete a medical assessment of the postpartum woman and evaluate the medical status of the infant.
3. Providers must have the capability to perform these services in the recipient's home.

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CHILDBIRTH EDUCATION PROGRAM

a.+2 Definition of Services:

The Childbirth Education Program is made up of two components. The first component is a series of six (6) childbirth preparation classes. These classes are designed to provide information concerning pregnancy, proper prenatal care, what to expect during labor and delivery and breastfeeding. The second component is comprised of two (2) classes. One class is designed to provide information on newborn feeding, e.g., bottle feeding, breastfeeding and general infant nutrition. The second class provides information on basic newborn care.

Limitations:

Recipients may take individual classes or the entire series. However, the same class may only be taken once every twelve (12) months. Recipients receiving services under the Childbirth Preparation component (six class series) must be pregnant women. Recipients receiving services under the Newborn Care or Newborn Feeding classes must be pregnant women or postpartum women. The postpartum period is defined as thirty days after maternal discharge.

Provider Qualifications:

Enrollment is open to all providers who meet the following requirements:

1. Instructors must be licensed practitioners of the healing arts.
2. Instructors must be certified as a childbirth educator by a national or state recognized certifying association.

b.+ Services for any other medical conditions that may complicate pregnancy are provided, as described in Attachments 3.1-A & B of this plan, to the same extent as for other recipients.

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State/Territory: GEORGIA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Services of Christian Science nurses.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

c. Care and services provided in Christian Science sanatoria.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

d. Nursing facility services for patients under 21 years of age.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

e. Emergency hospital services.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

*Description provided on attachment.

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